Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/HHSA

PRIOR AUTHORIZATION HOME HEALTH SERVICES ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE

PROVIDER INFORMATION

(6) PERFORMING PROVIDER'S NAME AND CREDENTIALS	(7) PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) PERFORMING PROVIDER'S TELEPHONE NUMBER
		( ) -

(9) REFERRING PROVIDER'S NAME	(10) REFERRING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER

A. Clinical condition and recipient history relative to the service requested: (including mobility, independence, cognitive ability, special problems, etc.)

B. Is the recipient confined to place of residence? ☐ Yes ☐ No

C. Is a primary care giver available? ☐ Yes ☐ No Explain:

D. Identify Home Health Aide services to be provided as they relate to the recipient's medical condition (be specific): (Include hours per day/days per week)

E. Identify the nursing services to be provided as they relate to the recipient's medical condition (be specific): (Include hours per day/days per week)

F. How long have requested service(s) been provided?

G. Identify the estimated duration of need:

H. Indicate progress/status since care was initiated or last authorized, and estimate the need for continued service:

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

I. _____ _____

Date Requesting Provider's Signature